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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

89793

9895

## CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Harford		MARYLAND		STATE Maryland		COUNTY Harford	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Aberdeen Rural		31/2 yrs.		TOWN Aberdeen Rural			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Ludda (Middle) (Last) Adams				(Month) (Day) (Year)			
				Oct. 10 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	Married	Sept. 12, 1890	65 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Farm tenant		Farm		Absher N.C.		U.S.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Joseph Adams				Susan Armes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
no		212-16-4295		Barbara Mittson, Aberdeen Md.			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
4221 IMMEDIATE CAUSE (A)				Cerebral Hemorrhage			
ANTECEDENT CAUSE(S) DUE TO				Cardiovascular			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO				Atherosclerosis			
				✓			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May 1953, to Oct 12, 1955, that I last saw the deceased alive on Oct 11, 1955, and that death occurred at 5:10 P.M. from the causes and on the date stated above.							
SIGNATURE		M.D.		ADDRESS (Street, city, town, state)		DATE SIGNED	
H. J. [Signature]				Baltimore Md		10/13/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Oct. 15, 1955		Conowingo Baptist		Conowingo Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE Oct. 13 '55		Bertha B. Knight		J. Earl Tyson, Rising Sun, Md.			

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OCT 19 1965

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C-1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09794

9785

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>HARFORD</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
24 TOWN <u>HAVRE DE GRACE</u>		14 DAYS		CITY OR TOWN <u>CARDIFF</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HARFORD Memorial Hosp.</u>				STREET ADDRESS (If rural give location) <u>/</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
TYPE OR PRINT <u>MARY BARNETT BEATTIE</u>				<u>October 18 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>FEMALE</u>	<u>WHITE</u>	<u>WIDOWED</u>	<u>JAN. 25, 1870</u>	<u>85</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>HOUSEWIFE</u>					<u>PENNSYLVANIA</u>		<u>U.S.A.</u>
13. FATHER'S NAME <u>John BARNETT</u>				14. MOTHER'S MAIDEN NAME <u>SUE Milligan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>				<u>MRS. MALCOLM SNODGRASS, MDI. BELAIR</u>			
<b>18. MEDICAL CERTIFICATION</b>							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							<u>18 hours</u>
IMMEDIATE CAUSE (A) <u>Respiratory failure</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized carcinomatosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Biliary tract carcinoma</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?	
<u>10-12-55</u>		<u>generalized carcinomatosis</u>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)			21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>10-12-55</u> , to <u>10-18-55</u> , that I last saw the deceased alive on <u>10-17-55</u> , and that death occurred at <u>3:15</u> M., from the causes and on the date stated above.							
SIGNATURE <u>James W.C. Finney</u>				ADDRESS (Street, city, town, state) <u>330 B. Union Ave. Havre de Grace, Md. 107855</u>			
DATE <u>Oct. 20-55</u>				DATE SIGNED <u>John H. Harkins, Delton, Pa.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>10-20-55</u>		<u>SLATE RIDGE</u>		<u>DELTA PA.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		<u>G. L. Lewis M.D.</u>		<u>John H. Harkins</u>		<u>Delton, Pa.</u>	

BUREAU V.

OCT 24 1955

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9786

09795

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. ....

I. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Harford County</u> MARYLAND		STATE <u>Maryland</u> COUNTY <u>Harford</u>		CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Street Rural</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>Street Rural</u> X	
TOWN <u>Lawrence Grace</u>		LENGTH OF STAY (in this place)		STREET ADDRESS (If rural, give location) <u>Rt. #1 near Hill Top Trines</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hosp</u>							
3. NAME OF DECEASED: (Type or Print)		(First) <u>Willard</u> (Middle) <u>Blevins</u> (Last) <u>Blevins</u>		4. DATE OF DEATH		5. DATE OF DEATH	
				<u>10 - 15</u> 19 <u>55</u>			
6. SEX: <u>Male</u>	7. COLOR OR RACE: <u>White</u>	8. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	9. DATE OF BIRTH: <u>May 2 - 1921</u>	10. AGE last birthday: <u>34</u> yrs.	11. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u>	12. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Concrete Business</u>		11. BIRTHPLACE (State or foreign country): <u>Ash County North Carolina</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>Oscar Blevins</u>				14. MOTHER'S MAIDEN NAME: <u>M. Mattie Wyatt</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u> (If Yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY No.: <u>  </u>		17. INFORMANT & ADDRESS: <u>Wm Finley Box 757 Aberdeen Md.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a) <u>Coronary occlusion</u> DUE TO							
Antecedent cause(s) (b) <u>  </u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) <u>  </u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M. <u>  </u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>William V. ...</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>10-16-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <u>  </u>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>10/16/55</u>		NAME OF CEMETERY OR CREMATORY: <u>Baro Cemetery</u>		LOCATION (City, town, or county) (State): <u>White Top, Grayson Co. Va.</u>	
DATE REC'D BY LOCAL REG. <u>Oct 17-55</u>		REGISTRAR'S SIGNATURE <u>A. L. Lewis</u>		24. FUNERAL DIRECTOR <u>John G. Darrington Aberdeen Md.</u>		ADDRESS <u>  </u>	

67101

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UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

1. Name of Subject	
2. Address	
3. Date of Birth	
4. Sex	
5. Race	
6. Height	
7. Weight	
8. Eyes	
9. Hair	
10. Complexion	
11. Occupation	
12. Education	
13. Social Security Number	
14. Date of Entry into Country	
15. Date of Departure from Country	
16. Date of Arrival at Destination	
17. Date of Departure from Destination	
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99. Date of Departure from Destination	
100. Date of Arrival at Destination	

BUREAU V. S.

OCT 18 1955

RECEIVED

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535



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INSTRUCTIONS

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VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09796

9896

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Hartford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Hartford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Sandy Hook Rd.</u>		<u>8 mo</u>		TOWN <u>Sandy Hook Road</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Michael Thomas Boggs</u>				<u>Oct 11 55</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<u>M</u>	<u>W</u>	<u>Single</u>	<u>AUG 9 1945</u>	<u>10</u> yrs.	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>School Boy</u>		<u>-</u>		<u>Balts City</u>		<u>USA</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Simon J Boggs</u>				<u>Ruth MATH</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>	
<u>-</u>				<u>-</u>		<u>Simon J. Boggs Street Rd. Md.</u>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>IMMEDIATE CAUSE</b> (A) <u>HODGKIN'S DISEASE</u>						<u>23 months</u>	
<b>ANTECEDENT CAUSE(S)</b> DUE TO							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b> (B)							
<b>STATING UNDERLYING CAUSE LAST.</b> DUE TO							
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> (C)							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21a. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from Nov. 53, to Oct. 11, 1955, that I last saw the deceased alive on Oct. 6, 1955, and that death occurred at 2:34 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Willard P. Hudson</u>				<b>ADDRESS</b> (Street, city, town, state) <u>M.D. Forest Hill, Md.</u>		<b>DATE SIGNED</b> <u>10-11-55</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>Burial</u>		<u>Oct 13-55</u>		<u>Bel Air Mem Gardens</u>		<u>Bel Air Md.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>16-14-55</u>		<u>Priscilla Foxwood</u>		<u>Matthew Foxwood</u>		<u>Sanctiville Md.</u>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

Hartford

Sandy Hook Rd. 2 mo

Hartford

Sandy Hook Rd.

Michael Thomas

Bodys

Oct 11

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School Rd

Simon 2 Bodys

North Main

Summit St. 1000

BUREAU A. 2

222

Bureau / Oct 13-22 Bel Air Men gardens  
Bel Air Rd.  
Baltimore



**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9787

## CERTIFICATE OF DEATH

09797

Reg. Dist. No. 185

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Harward Grace</u>				TOWN <u>Bel Air, Maryland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u>				STREET ADDRESS (If rural give location)			
				RT. #1 Box 374			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>John</u> (Middle) <u>Foy</u> (Last) <u>Carico</u>				(Month) <u>October</u> (Day) <u>11</u> (Year) <u>1955</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Married</u>	<b>8. DATE OF BIRTH</b> <u>8/29/1876</u>	<b>9. AGE last birthday</b> <u>79</u> yrs.	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
				Months		Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Farm self emp.</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Virginia</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Creed M. Carico</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Emaline Shuler</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Claude F. Carico Bel Air, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>						<u>Sudden</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Artery Disease</u>						<u>2</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Generalized Arterio-sclerosis</u>						<u>+</u>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>May 1, 1950</u> , to <u>Oct 11, 1955</u> , that I last saw the deceased alive on <u>Oct 11, 1955</u> , and that death occurred at <u>3:19 P.M.</u> , from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>Willard P. Heedson M.D.</u>				<b>ADDRESS</b> (Street, city, town, state) <u>Forest Hill</u>		<b>DATE SIGNED</b> <u>11/11/55</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>10/14/55</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Bel Air Memorial Gardens</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Bel Air Harford Co. Md.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>A. L. Lewis M.D.</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John G. Barrington</u>		<b>ADDRESS</b> <u>Abertown Md.</u>	
<b>DATE</b> <u>Oct 14 - 1955</u>							

00303

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

# DEATH CERTIFICATE

REG. DIV. 100

1. NAME OF DECEASED

DATE OF BIRTH

SEX

DATE OF DEATH

PLACE OF DEATH

BUREAU V. S.

OCT 12 1925

RECEIVED

INVESTIGATION

1. I hereby certify that the above is a true and correct copy of the original as filed in my office.  
2. I hereby certify that the above is a true and correct copy of the original as filed in my office.  
3. I hereby certify that the above is a true and correct copy of the original as filed in my office.  
4. I hereby certify that the above is a true and correct copy of the original as filed in my office.  
5. I hereby certify that the above is a true and correct copy of the original as filed in my office.  
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7. I hereby certify that the above is a true and correct copy of the original as filed in my office.  
8. I hereby certify that the above is a true and correct copy of the original as filed in my office.  
9. I hereby certify that the above is a true and correct copy of the original as filed in my office.  
10. I hereby certify that the above is a true and correct copy of the original as filed in my office.

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9788

## CERTIFICATE OF DEATH

09798

Reg. Dist. No. 182

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>HARTFORD</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>HARTFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>32</u> TOWN <u>Bel Air</u>		LENGTH OF STAY (in this place) <u>21 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bel Air</u>		<u>32</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				STREET ADDRESS (If rural give location) <u>1</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>Mahala</u> <u>N.</u> <u>CHAMBERS</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>OCT</u> <u>1</u> 19 <u>55</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Sept 13-1873</u>	9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House duties</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>HARTFORD CO. MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>
13. FATHER'S NAME <u>JOHN W. CHAMBERS</u>				14. MOTHER'S MAIDEN NAME <u>Alice Collins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, for unk.) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT & ADDRESS <u>Alice Chambers Bel Air, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
422.1 IMMEDIATE CAUSE (A) <u>Arteriosclerotic CV disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u>	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>May 15, 1955</u> , to <u>Oct 1, 1955</u> , that I last saw the deceased alive on <u>Sept 30, 1955</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Harold C Palmer</u>		M.D. <u>Baltimore, Md.</u>		ADDRESS (Street, city, town, state) <u>1012/55</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>Oct 4/55</u>		NAME OF CEMETERY OR CREMATORY <u>CLARK'S CHAPEL</u>		LOCATION (City, town, or county) (State) <u>Gibson Hartford Co Md</u>	
24. REC'D BY REGISTRAR DATE <u>10-3-55</u>		REGISTRAR'S SIGNATURE <u>Priscilla Snowdon</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph T. Foster</u>		ADDRESS <u>Bel Air, Md.</u>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

80795

3278

DEATH CERTIFICATE

DEATH CERTIFICATE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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BUREAU V. S.

OCT 6 1955

RECEIVED

NOT FOR DISTRIBUTION

## 9789 CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Hartford</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Hartford</u>	
CITY OR TOWN <u>Bel Air</u>		LENGTH OF STAY (in this place) <u>25 years</u>		CITY OR TOWN <u>Bel Air Md</u>		32	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>309 Thomas St</u>				STREET ADDRESS (If rural give location)		1	
3. NAME OF DECEASED (Type or Print) <u>HARRY</u> (First) <u>Chilimidos</u> (Middle) <u>Childs</u> (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 22</u> 19 <u>55</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>1893</u>	9. AGE last birthday <u>62</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Restaurant Business</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>Greece</u>	
13. FATHER'S NAME <u>Andrew Chilimidos</u>				14. MOTHER'S MAIDEN NAME <u>Agatha Mitakis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT & ADDRESS <u>Benjamin Childs 309 Thomas St</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
1420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>None</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 1, 1940</u> , to <u>Oct 22, 1955</u> , that I last saw the deceased alive on <u>Oct 10, 1955</u> , and that death occurred at <u>4A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Louise C Palmer MD</u>				ADDRESS (Street, city, town, state) <u>Bel Air Md</u>		DATE SIGNED <u>10/22/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct 25/55</u>		NAME OF CEMETERY OR CREMATORY <u>Greek Orthodox</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Priscilla Lawrence</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J Foster</u>		ADDRESS <u>Bel Air Md</u>	
DATE <u>10-24-55</u>							

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ABC 1-55 10M



00750

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

# CERTIFICATE OF DEATH

Form 10-1-10

1. USAT HOSPITALS, INC. AND DR. DECKER

2. PLACE OF DEATH

3. PLACE OF BIRTH

4. PLACE OF DEATH

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43. PLACE OF DEATH

44. PLACE OF DEATH

BUREAU V. S.

OCT 22 1915

RECEIVED

CERTIFICATE

1. Name of deceased  
2. Sex  
3. Age  
4. Date of birth  
5. Date of death  
6. Place of birth  
7. Place of death  
8. Cause of death  
9. Signature of physician  
10. Signature of registrar  
11. Signature of informant  
12. Signature of witness  
13. Signature of registrar  
14. Signature of informant  
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96. Signature of witness  
97. Signature of registrar  
98. Signature of informant  
99. Signature of witness  
100. Signature of registrar



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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9790

## CERTIFICATE OF DEATH

09800

Reg. Dist. No. 185

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Harford-de-Bree</u>		<u>4 hrs.</u>		TOWN <u>Harford-de-Bree</u>		<u>24</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>Chesapeake Drive</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Leslie</u> (First) (Middle) (Last) <u>Daniel</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>10-3-1955</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>6/29/1898</u>	9. AGE last birthday <u>57</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u>		IF UNDER 24 HRS. Hours <u>3</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waiter Restaurant</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Langburg, N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Mr. M. Daniel</u>				14. MOTHER'S MAIDEN NAME <u>Kelias P. High</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Mr. Mary G. Daniel, Harford, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
420.1 IMMEDIATE CAUSE (A) <u>Acute Coronary Thrombosis with myo-</u>							
ANTECEDENT CAUSE(S) DUE TO <u>Cardiac infarction and Cardiac de-</u>						<u>1 day.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO <u>Arteriosclerotic Cardiovascular disease</u>						<u>unknown.</u>	
STATING UNDERLYING CAUSE LAST, (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that attended the deceased from <u>Oct 3rd, 1955</u> to <u>Oct 3rd, 1955</u> , that I last saw the deceased alive on <u>Oct 3rd, 1955</u> , and that death occurred at <u>7:12 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Stanley Tropp</u>		DATE THEREOF <u>10/7/55</u>		NAME OF CEMETERY OR CREMATORY <u>M.D. 420 N. Union Ave. Harford de Grace Ind.</u>		DATE SIGNED <u>10/4/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR <u>G. L. Lewis M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Peary...</u>		ADDRESS <u>Richmond, Va.</u>	
DATE <u>Oct. 5-1955</u>		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	

# CERTIFICATE OF DEATH

Reg. No. 100

1. Name of Deceased: *John Doe*

2. Sex: *Male*

3. Age: *45*

4. Date of Birth: *1910*

5. Place of Birth: *Baltimore, Maryland*

6. Date of Death: *1955*

7. Cause of Death: *Heart Disease*

8. Medical Certification

9. Signature of Physician

10. Date of Certification

11. Signature of Registrar

BUREAU V. 2

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THIS CERTIFICATE OF DEATH IS A STATUTORY REQUIREMENT AND MUST BE FILED WITH THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MD. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT THIS CERTIFICATE IS COMPLETED AND FILED IN THE APPROPRIATE MANNER. THE REGISTRAR IS NOT RESPONSIBLE FOR THE ACCURACY OF THE INFORMATION FURNISHED HEREON.

09801

## 9807 CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH COUNTY <u>Harford</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>MT ABERDEEN</u> LENGTH OF STAY (In this place) <u>7 years</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Long Bar Harbour</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Harford</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>MT ABERDEEN</u> STREET ADDRESS (If rural give location) <u>Long Bar Harbour</u>	
3. NAME OF DECEASED (Type or Print) <u>MAGDALENA</u> (First) (Middle) (Last) <u>DINKA</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 30 1955</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>July 24, 1896</u>
9. AGE last birthday <u>59</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>CZECHOSLOVAKIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>MICHAEL Maphiea</u>		14. MOTHER'S MAIDEN NAME <u>ROSE (Do-Not-Know)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>—</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-10-4483</u>	
17. INFORMANT & ADDRESS <u>John Vinka Sr. Long Bar Harbor, Abingdon rd.</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 155X IMMEDIATE CAUSE (A) <u>CARCINOMA of GALL-BLADDER</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>GENERALIZED METASTASES</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>—</u>		18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
19. DATE OF OPERATION <u>Oct 10, 1955</u>		19b. MAJOR FINDINGS OF OPERATION <u>Ca Gall-bladder &amp; Meta-Tases</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 4, 1955</u> , to <u>Oct 30, 1955</u> , that I last saw the deceased alive on <u>Oct 29, 1955</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>A. Sundecki M.D.</u> M.D.		ADDRESS (Street, city, town, state) <u>Bel Air, Md.</u> DATE SIGNED <u>10.30.1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>Nov 1-1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Riverhurst Cemetery</u>		LOCATION (City, town, or county) (State) <u>Indicott, New York</u>	
24. REC'D BY REGISTRAR <u>Willie R. Perry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Varring</u>	
DATE <u>Nov. 1-1955</u>		ADDRESS <u>Abingdon rd.</u>	

INSTRUCTIONS

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TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-53 10M

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NOV 2 1955

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1. NAME OF DECEASED		2. DATE OF DEATH	
3. PLACE OF DEATH		4. CAUSE OF DEATH	
5. SEX		6. AGE	
7. OCCUPATION		8. MARITAL STATUS	
9. EDUCATION		10. RELIGION	
11. BIRTH DATE		12. BIRTH PLACE	
13. MOTHER'S NAME		14. FATHER'S NAME	
15. SOCIAL SECURITY NUMBER		16. MEDICAL CERTIFICATION	
17. SIGNATURE OF DECEASED		18. SIGNATURE OF WITNESS	
19. SIGNATURE OF PHYSICIAN		20. SIGNATURE OF CORONER	
21. SIGNATURE OF JURY		22. SIGNATURE OF JUDGE	
23. SIGNATURE OF PROSECUTOR		24. SIGNATURE OF DEFENSE ATTORNEY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JUDGE	
27. SIGNATURE OF PROSECUTOR		28. SIGNATURE OF DEFENSE ATTORNEY	
29. SIGNATURE OF JURY		30. SIGNATURE OF JUDGE	
31. SIGNATURE OF PROSECUTOR		32. SIGNATURE OF DEFENSE ATTORNEY	
33. SIGNATURE OF JURY		34. SIGNATURE OF JUDGE	
35. SIGNATURE OF PROSECUTOR		36. SIGNATURE OF DEFENSE ATTORNEY	
37. SIGNATURE OF JURY		38. SIGNATURE OF JUDGE	
39. SIGNATURE OF PROSECUTOR		40. SIGNATURE OF DEFENSE ATTORNEY	
41. SIGNATURE OF JURY		42. SIGNATURE OF JUDGE	
43. SIGNATURE OF PROSECUTOR		44. SIGNATURE OF DEFENSE ATTORNEY	
45. SIGNATURE OF JURY		46. SIGNATURE OF JUDGE	
47. SIGNATURE OF PROSECUTOR		48. SIGNATURE OF DEFENSE ATTORNEY	
49. SIGNATURE OF JURY		50. SIGNATURE OF JUDGE	
51. SIGNATURE OF PROSECUTOR		52. SIGNATURE OF DEFENSE ATTORNEY	
53. SIGNATURE OF JURY		54. SIGNATURE OF JUDGE	
55. SIGNATURE OF PROSECUTOR		56. SIGNATURE OF DEFENSE ATTORNEY	
57. SIGNATURE OF JURY		58. SIGNATURE OF JUDGE	
59. SIGNATURE OF PROSECUTOR		60. SIGNATURE OF DEFENSE ATTORNEY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JUDGE	
63. SIGNATURE OF PROSECUTOR		64. SIGNATURE OF DEFENSE ATTORNEY	
65. SIGNATURE OF JURY		66. SIGNATURE OF JUDGE	
67. SIGNATURE OF PROSECUTOR		68. SIGNATURE OF DEFENSE ATTORNEY	
69. SIGNATURE OF JURY		70. SIGNATURE OF JUDGE	
71. SIGNATURE OF PROSECUTOR		72. SIGNATURE OF DEFENSE ATTORNEY	
73. SIGNATURE OF JURY		74. SIGNATURE OF JUDGE	
75. SIGNATURE OF PROSECUTOR		76. SIGNATURE OF DEFENSE ATTORNEY	
77. SIGNATURE OF JURY		78. SIGNATURE OF JUDGE	
79. SIGNATURE OF PROSECUTOR		80. SIGNATURE OF DEFENSE ATTORNEY	
81. SIGNATURE OF JURY		82. SIGNATURE OF JUDGE	
83. SIGNATURE OF PROSECUTOR		84. SIGNATURE OF DEFENSE ATTORNEY	
85. SIGNATURE OF JURY		86. SIGNATURE OF JUDGE	
87. SIGNATURE OF PROSECUTOR		88. SIGNATURE OF DEFENSE ATTORNEY	
89. SIGNATURE OF JURY		90. SIGNATURE OF JUDGE	
91. SIGNATURE OF PROSECUTOR		92. SIGNATURE OF DEFENSE ATTORNEY	
93. SIGNATURE OF JURY		94. SIGNATURE OF JUDGE	
95. SIGNATURE OF PROSECUTOR		96. SIGNATURE OF DEFENSE ATTORNEY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JUDGE	
99. SIGNATURE OF PROSECUTOR		100. SIGNATURE OF DEFENSE ATTORNEY	

80000 CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

100000

THE ENCLOSURE

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9791

## CERTIFICATE OF DEATH

09802

Reg. Dist. No. 185

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>House of Grace</u>		<u>5 days</u>		TOWN <u>Perry Point</u>		<u>07X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Mem. Hospital</u>				STREET ADDRESS (If rural give location) <u>Box 702</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Ernest Roosevelt Dishman</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>October 25 1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>June 1, 1912</u>	9. AGE last birthday <u>43</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attendant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. V. Hospital</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>David Dishman</u>				14. MOTHER'S MAIDEN NAME <u>Lena Moore</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>470-01-8499</u>		17. INFORMANT & ADDRESS <u>Bessie A. Dishman, Perry Point, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
420-1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Myocarditis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>MI</u> <b>19</b> <u>53</u> , <b>to</b> <u>10 25</u> , <b>19</b> <u>55</u> , <b>that I last saw the deceased alive on</b> <u>10-23</u> , <b>19</b> <u>55</u> , <b>and that death occurred at</b> <u>9:15 A.M.</u> , <b>from the causes and on the date stated above.</b> <b>SIGNATURE</b> <u>A. L. Lewis M.D.</u> <b>ADDRESS (Street, city, town, state)</b> <u>Harford &amp; Shreve M.D.</u> <b>DATE SIGNED</b> <u>10-25-55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10-28-55</u>		NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem.</u>		LOCATION (City, town, or county) (State) <u>Bladensburg Rd., Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>A. L. Lewis M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wesley Patterson &amp; Son, Perryville, Md.</u>		ADDRESS	
DATE <u>Oct. 27-1955</u>							







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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09803

9792

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
24 TOWN <u>Harve de Grace</u>		10 DAYS		TOWN <u>Annapolis</u>		02X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
71 <u>Harford Memorial Hospital</u>				<u>R.D. # 2</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>Frances</u> (Middle) <u>Sophia</u> (Last) <u>Dorring</u>				(Month) <u>October</u> (Day) <u>18</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>Caucas</u>		<u>7/15/1873</u>	<u>82</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>House Wife</u>		<u>Home</u>		<u>MD</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>CHARLES H. PITEOCK</u>				<u>ARBELLA LEIGHT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Mr. Franklin O. Dorring</u> <u>Annapolis Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
420.1 IMMEDIATE CAUSE (A) <u>Cerebral embolism</u>				INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Myocardial infarction</u>				<u>5 days</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Coronary occlusion state</u>				<u>5 days</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerosis -</u>				<u>10 years</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 14</u> , 19 <u>55</u> , to <u>Oct 18</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct 18</u> , 19 <u>55</u> , and that death occurred at <u>8 P.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Franklin O. Dorring</u>				ADDRESS (Street, city, town, state) <u>Harve de Grace Md.</u>		DATE SIGNED <u>Oct 18 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10-21-55</u>		<u>Mountain Ch. Yard.</u>		<u>Harford Co. Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Oct 20-55</u>		<u>G. L. Lewis M.D.</u>		<u>R. Madison Mitchell</u>		<u>Harve de Grace Md.</u>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9793

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09804  
Reg. Dist.

No. 185

<b>1. PLACE OF DEATH:</b> COUNTY <u>Harford</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Harrods Grace</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>201 Harford Memorial Hospital</u>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> STATE <u>Md</u> COUNTY <u>Cecil</u> CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Port Deposit 07x-2</u> STREET ADDRESS (If rural, give location) <u>73 North Main</u>	
<b>3. NAME OF DECEASED:</b> (Type or Print) (First) (Middle) (Last) <u>Joseph Rawlings Gibson</u>		<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Oct. 4 1953</u>	
<b>5. SEX:</b> <u>Male</u>	<b>6. COLOR OR RACE:</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED,</b> (Specify) <u>Married</u>	<b>8. DATE OF BIRTH:</b> <u>July 11, 1911</u>
<b>9. AGE last birthday:</b> <u>44</u> yrs.		<b>10. BIRTHPLACE</b> (State or foreign country) <u>Md</u>	
<b>11. USUAL OCCUPATION</b> (Give kind of work done during most of work life, even if retired) <u>Gen. Store</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME:</b> <u>James W. Gibson</u>		<b>14. MOTHER'S MAIDEN NAME:</b> <u>Bessie E. French</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No.</u>		<b>16. SOCIAL SECURITY No.:</b> <u>216-07-1782</u>	
<b>17. INFORMANT &amp; ADDRESS:</b> <u>Flavence Gibson, Port Deposit, Md</u>			

<b>18. MEDICAL CERTIFICATION</b> <b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:</b> Immediate cause (a) <u>Fracture skull</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)		INTERVAL BETWEEN ONSET AND DEATH —
---	--	---------------------------------------

<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Fracture R femur</u>		—
<b>19a. DATE OF OPERATION:</b>		<b>19b. MAJOR FINDING OF OPERATION:</b>
<b>20. AUTOPSY?</b> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		

<b>21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b> <input type="checkbox"/>	<b>21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY</b> <u>Swingman's Bridge Route 40 Perryville, Cecil</u>	<b>21c. (City or town) (County) (State)</b> <u>1 Md.</u>
<b>21d. TIME (Month) (Day) (Year) (Hour) OF INJURY</b> <u>10/4/55 12:40 A. M.</u>	<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	<b>21f. HOW DID INJURY OCCUR?</b> <u>Auto accident, auto - auto type</u>

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE Gerald C Palmer

CHIEF MEDICAL EXAMINER ☐ DATE SIGNED  
 DEPUTY MEDICAL EXAMINER ☐  
 M. D. ASSISTANT MEDICAL EXAM. 10/4/55

<b>23. BURIAL, CREMATION, REMOVAL (Specify):</b> <u>Burial</u>	<b>DATE THEREOF</b> <u>Oct. 7, 1953</u>	<b>NAME OF CEMETERY OR CREMATORY</b> <u>Holmes</u>	<b>LOCATION (City, town, or county) (State)</b> <u>Port Deposit, Md</u>
<b>DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE</b> <u>Oct 5 - 1955 G. L. Lewis m.d.</u>		<b>24. FUNERAL DIRECTOR</b> <u>Geo. Patterson &amp; Son, Perryville, Md.</u>	

BUREAU V. S.

OCT 6 1955

RECEIVED

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## CERTIFICATE OF DEATH

Reg. Dist. No. 182

## 1. PLACE OF DEATH:

COUNTY **HARFORD**

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)

LENGTH OF STAY (in this place)

X TOWN **RURAL - STREET****71 yrs.**

HOSPITAL OR INSTITUTION OR STREET ADDRESS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **MD.**COUNTY **HARFORD**CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN **RURAL - STREET** X

STREET ADDRESS (If rural give location)

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

**CHARLES AUGUSTINE GLACKIN**

4. DATE (Month)

(Day)

(Year)

OF DEATH: **OCT. 20, 1955**

## 5. SEX:

**M**

## 6. COLOR OR RACE:

**W**

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED.

(Specify)

**MARRIED**

## 8. DATE OF BIRTH:

**AUG. 20, 1884**

## 9. AGE last birthday

**71**

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): **FARMER**10B. KIND OF BUSINESS OR INDUSTRY: **AGRI.**11. BIRTHPLACE (State or foreign country): **HARFORD CO., MD.**12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

## 13. FATHER'S NAME:

**CHARLES R. GLACKIN**

## 14. MOTHER'S MAIDEN NAME:

**CAROLINE R. SWEENEY**15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unk.) (If Yes, give war or dates of service) **No**

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT &amp; ADDRESS:

**MRS. MAHALA GLACKIN, STREET, MD.**

## 18. MEDICAL CERTIFICATION

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## IMMEDIATE CAUSE

(A)

**CARCINOMA of the Head of**

## ANTECEDENT CAUSE (B)

DUE TO

**PAN CREAS**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B)

DUE TO

(C)

## II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

## INTERVAL BETWEEN ONSET AND DEATH

**1 yr**

## 19A. DATE OF OPERATION:

**July 1955**

## 19B. MAJOR FINDINGS OF OPERATION

**Carcinoma of the Head of pancreas**

## 20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **May 23, 1955**, to **OCT 20, 1955**, that I last saw the deceased alive on **OCT 20, 1955**, and that death occurred at **12/5P M.** from the causes and on the date stated above.

SIGNATURE

**Malcolm Dudley Phillips**

M. D.

ADDRESS

**Sealington, Ind**

DATE SIGNED

**10/23/55**

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

**BURIAL****10-24-55****ST. MARYS****PLESVILLE, MD.**

DATE REC'D BY LOCAL REGISTRAR

**10-23-55**

REGISTRAR'S SIGNATURE

**Patricia Foxwood**

24. FUNERAL DIRECTOR

ADDRESS

**JOHN H. HARKINS, DELTA, PA.**

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

CT 17 1955

BUREAU V. S.

SECURITY BOND



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09806

9899

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Hartford</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Hartford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Pulnam Road</u>		<u>45 yrs</u>		TOWN <u>Pulnam Road</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>00</u>				<u>Forest Hill, Rd</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) (Middle) (Last)				(Month) (Day) (Year)			
<u>William Stanley Gover</u>				<u>Oct 23 1955</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>		<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>	
<u>Male</u>	<u>Eccl</u>	<u>married</u>	<u>Feb 24 1890</u>		<u>65</u> yrs.	Months	Days
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>Farmer</u>		<u>General</u>		<u>Madonna Md</u>		<u>USA</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>George Gover</u>				<u>Martha A. Hall</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>No</u>		<u>27-23-6076</u>		<u>Edna A. Gover Forest Hill Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<u>422.1</u>						<u>20 min. (approx)</u>	
<b>IMMEDIATE CAUSE (A)</b>							
<u>Cerebral thrombosis</u>							
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b>							
<b>STATING UNDERLYING CAUSE LAST, DUE TO</b>							
<u>Chronic cardio-vascular disease</u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<u>None</u>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b>			
<u>8</u>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>May</u>, 19<u>54</u>, to <u>October</u>, 19<u>55</u>, that I last saw the deceased alive on <u>Oct. 15</u>, 19<u>55</u>, and that death occurred at <u>8:45a</u> M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>DATE SIGNED</b>			
<u>Willard P. Hudson</u> M.D.				<u>October 25, 1955</u>			
<b>ADDRESS (Street, city, town, state)</b>							
<u>Forest Hill, Md.</u>							
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>	<b>DATE THEREOF</b>	<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county)</b>		<b>(State)</b>	
<u>Burial</u>	<u>Oct 26 55</u>	<u>Fairview</u>		<u>Forest Hill, Hartford, Md</u>			
<b>24. REC'D BY REGISTRAR</b>	<b>REGISTRAR'S SIGNATURE</b>			<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>			
<u>10-29-56</u>	<u>Priscilla Howard</u>			<u>Martha E. Shultz</u>			
<b>DATE</b>				<b>ADDRESS</b>			
				<u>Janet Wolfe</u>			

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

Harford

Putnam Road Harford

Harford

Putnam Road

Forest Hill, Md

Oct 22, 1955

Male

Farmer

George Power

Age

21-23-44-48-52-56-60-64-68-72-76-80-84-88-92-96-100

Martha A Hall

1955

Married Feb 24, 1912

2

BUREAU V. 8

Received Oct 25, 1955

Forest Hill, Md

Martha A Hall

Oct 31 1955

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-35 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09807

9810

## CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Harford</b>		STATE <b>Maryland</b>		COUNTY <b>Harford</b>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>Joppa, R.D.</b>		<b>26 yrs.</b>		TOWN <b>Joppa, R.D.</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>Samuel</b> (Middle) <b>Slater</b> (Last) <b>Greenfield</b>				(Month) <b>Oct.</b> (Day) <b>2,</b> (Year) <b>19 55</b>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<b>male</b>	<b>white</b>	<b>married</b>	<b>May 8, 1893</b>	<b>62</b> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<b>Stock Clerk</b>		<b>U.S. Govt.,</b>		<b>Maryland</b>		<b>U.S.A.</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<b>Samuel B. Greenfield</b>				<b>Wilanna Black</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<b>no</b>		<b>218-03-0888</b>		<b>Mrs. Pearl E. Greenfield, Joppa, Md.</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
782.4 IMMEDIATE CAUSE (A) <b>Auto cardio resp. failure</b>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO <b>Myocardial infarction</b>						<b>immediate</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)						<b>2 years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at <b>2:30 P.</b> M, from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
<b>Howard K. McCombs</b>		<b>Joppa, Harford, Md.</b>		<b>3 Oct 55</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)			
<b>Burial</b>		<b>Mountain Christian</b>		<b>Joppa, Harford, Md.</b>			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<b>Oct 4, 1955</b>		<b>Norma G. Moore</b>		<b>Howard K. McCombs &amp; Son</b>		<b>Abingdon, Md.</b>	



9811

## CERTIFICATE OF DEATH

Reg. Dist. No. 182.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>HARFORD</b>		MARYLAND		STATE <b>MD.</b>		COUNTY <b>HARFORD</b>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<b>WHITEFORD</b>		<b>66 yrs.</b>		<b>WHITEFORD</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH:			
<b>DAVID ELWOOD HUGHES</b>				<b>OCT. 29 1955</b>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<b>M</b>	<b>W</b>	<b>MARRIED</b>	<b>MAY 18, 1889</b>	<b>66</b> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<b>SLATE CUTTER</b>		<b>SLATE</b>		<b>WHITEFORD, MD.</b>		<b>U.S.A.</b>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<b>THOMAS HUGHES</b>				<b>JULIA MORRISON</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<b>No</b>		<b>185-09-9769</b>		<b>Mrs. KATHRYN HUGHES, WHITEFORD</b>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>161X Carcinoma of larynx</b>							<b>2 yrs.</b>
ANTECEDENT CAUSE (S) <b>with metastasis.</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>Nov. 1953</b>		<b>Carcinoma of larynx</b>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Aug. 28, 1949</b> , to <b>Oct. 20, 1955</b> , that I last saw the deceased alive on <b>Oct. 20, 1955</b> and that death occurred at <b>11:15 AM</b> , from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<b>Charles A. Neff MD</b>		<b>Streeb Md.</b>		<b>Oct 22, 1955</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>BURIAL</b>		<b>10-24-55</b>		<b>Emory</b>		<b>STREET, MD.</b>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<b>10-23-55</b>		<b>W. C. Woodward</b>		<b>JOHN H. HARKINS, DELTA, PA.</b>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

OCT 27 1955

BUREAU V. 1

VEGETABLE BOND

REVERTA



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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-95 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9794

## CERTIFICATE OF DEATH

09809

Reg. Dist. No. 185

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>HARFORD</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>HAURE DE GRACE</u>		LENGTH OF STAY (in this place) <u>3 1/2 DAYS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>RURAL Rt # 2</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>71 HARFORD MEMORIAL HOSP.</u>				STREET ADDRESS (If rural give location) <u>HAURE DE GRACE</u>		<u>1</u>	
<b>3. NAME OF DECEASED</b> (Type or Print) <u>KATHERINE S LEE</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>OCTOBER 31 19 55</u>			
<b>5. SEX</b> <u>FEMALE</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowed</u>	<b>8. DATE OF BIRTH</b> <u>1/16/1881</u>	<b>9. AGE last birthday</b> <u>74</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	<b>IF UNDER 24 HRS.</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>none</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>MARYLAND</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>
<b>13. FATHER'S NAME</b> <u>CHARLES Kincaid</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>SARAH Knight</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>			<b>16. SOCIAL SECURITY NO.</b> <u>unknown</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>C. Silver Lee, Haure de Grace, Md.</u>		
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>153X IMMEDIATE CAUSE</b> (A) <u>Carcinoma of sigmoid Colon with</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO <u>metastasis</u>						<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Arteriosclerotic Cardiovascular disease</u>						<u>?</u>	
<b>19a. DATE OF OPERATION</b> <u>10/31/55</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.) <u>M.</u>		<b>21e. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>Oct. 1st, 1955</u> , to <u>Oct. 31st, 1955</u> , that I last saw the deceased alive on <u>Oct. 31st, 1955</u> , and that death occurred at <u>1:00 P.M.</u> from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>Edward L. Brown</u>				<b>ADDRESS</b> (Street, city, town, state) <u>M.D. 420 North Union Ave., Haure de Grace, Md.</u>		<b>DATE SIGNED</b> <u>10/31/55</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>11/2/55</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Rock Run</u>		<b>LOCATION (City, town, or county) (State)</b> <u>Level, Harford Co. Md.</u>	
<b>24. REC'D BY REGISTRAR</b> DATE <u>11-2-55</u>		<b>REGISTRAR'S SIGNATURE</b> <u>A. L. Lewis M.D.</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Edward L. Brown</u>		<b>ADDRESS</b> <u>Haure de Grace, Md.</u>	

RECEIVED

RECEIVED  
U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE  
BUREAU OF VITAL STATISTICS  
WASHINGTON, D.C. 20540  
NOV 3 1955

# CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH, EDUCATION & WELFARE

01503

Page No. 10

1. NAME OF DECEASED

DECEASED

2. PLACE OF DEATH

3. DATE OF DEATH

4. TIME OF DEATH

5. PLACE OF BIRTH

6. DATE OF BIRTH

7. SEX

8. OCCUPATION

9. CAUSE OF DEATH

10. MEDICAL CERTIFICATION

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEXT OF KIN

16. SIGNATURE OF CLERK

17. SIGNATURE OF CHIEF OF BUREAU

18. SIGNATURE OF ASSISTANT CHIEF OF BUREAU

19. SIGNATURE OF DEPUTY CHIEF OF BUREAU

20. SIGNATURE OF CLERK

21. SIGNATURE OF CHIEF OF BUREAU

22. SIGNATURE OF ASSISTANT CHIEF OF BUREAU

BUREAU V. S.

NOV 3 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9795				09810	
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18					
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 182					
1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Harford</u>		MARYLAND	STATE <u>N. C.</u>		COUNTY <u>Robeson</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>322 Be/Air</u>		LENGTH OF STAY (in this place) <u>Transient</u>	CITY (If outside corporate limits write RURAL and give nearest town) <u>Rowland</u>		<u>70x.3</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>			STREET ADDRESS (If rural, give location) <u>Route 1</u>		
3. NAME OF DECEASED:			4. DATE OF DEATH		
(First) <u>Boyd</u> (Middle) <u>Lindsay</u> (Last) <u>Lindsay</u>			(Month) <u>October</u> (Day) <u>18</u> (Year) <u>1955</u>		
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>April 7 - 1910</u>	9. AGE last birthday: <u>45</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Farmer</u>		11. BIRTHPLACE (State or foreign country): <u>N. Carolina</u>	
13. FATHER'S NAME: <u>Will Lindsay</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>✓</u>			16. SOCIAL SECURITY No.: <u>✓</u>		
17. INFORMANT & ADDRESS: <u>Henry Lindsay Rayhan N.C.</u>					
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
420.1 Immediate cause (a) <u>Coronary occlusion</u> DUE TO					
Antecedent cause(s) (b) <u>Hypertension</u> DUE TO					
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>Gerald C Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>10/18/55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Oct 21/55</u>		NAME OF CEMETERY OR CREMATORY <u>Rayhan Baptist</u>	
LOCATION (City, town, or county) (State) <u>Rowland Robeson Co NC</u>		24. FUNERAL DIRECTOR <u>Joe H. Belam</u> ADDRESS			
DATE REC'D BY LOCAL REG. <u>10-18-55</u>		REGISTRAR'S SIGNATURE <u>Mrs. Ella Lowndes</u>			

RECEIVED

OCT 20 1955

BUREAU V. S.

9812

## CERTIFICATE OF DEATH

098142  
Reg. Dist. No. 102

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MD HARFORD</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL, and give nearest town)		OR	
TOWN <u>STREET RD.</u>		<u>10 yrs.</u>		TOWN <u>RURAL</u>		STREET <u>STREET</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>FANNIE C LOWE</u>				<u>10 - 10 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F.</u>	<u>W</u>		<u>5-12-1885</u>	<u>70</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country): <u>PHYESVILLE, MD</u>	
13. FATHER'S NAME: <u>GRAFTON DEVOE</u>				14. MOTHER'S MAIDEN NAME: <u>Rebecca THOMPSON</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.: <u>NONE</u>		17. INFORMANT & ADDRESS: <u>Mrs. Edward Marcelle, Street Ind.</u>	

18. MEDICAL CERTIFICATION				Interval Between Onset And Death	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
<u>422.2</u>				<u>2 yrs.</u>	
Immediate cause (a) <u>Bronchial Pneumonia</u>				<u>5 yrs.</u>	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Chronic Bronchitis</u>				<u>6 yrs.</u>	
(c) <u>Chronic myocarditis</u>					
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
SUICIDE		OF			
HOMICIDE		INJURY			
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED		HOW DID INJURY OCCUR?	
OF INJURY		While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from <u>April 1953</u> to <u>Oct. 9, 1955</u> , that I last saw the deceased alive on <u>Oct. 9, 1955</u> and that death occurred at <u>6:30 a.m.</u> , from the causes and on the date stated above.					
SIGNATURE		(Degree or title)		DATE SIGNED	
<u>F. P. Smokey</u>		<u>M.D.</u>		<u>Harlington MD 10/10/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>10-12-55</u>		<u>FRIENDS</u>	
LOCATION (City, town, or county) (State)		DATE REC'D BY LOCAL REGISTRAR		FUNERAL DIRECTOR	
<u>FAWN GROVE, YORK CO., PA.</u>		<u>16-11-55</u>		<u>W. Howard With Fawn Grove Pa.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
OCT 13 1955  
BUREAU V. S.



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09812

9813

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Hartford</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>Baltimore</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <i>Darlington Md</i>		<i>2 week</i>		TOWN <i>Whitemarsh</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Walters Convalescent Home</i>				STREET ADDRESS (If rural give location) <i>Rural</i>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<i>Lapola</i> (First) <i>Lurding</i> (Middle) <i>Lurding</i> (Last)				<i>Oct. 26</i> 19 <i>55</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>Male</i>	<i>White</i>	<i>widower</i>	<i>May 23 1868</i>	<i>87</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY
<i>Farmer</i>					<i>Blacksburg, Indiana</i>		<i>U.S.</i>
13. FATHER'S NAME <i>Benjamin Lurding</i>				14. MOTHER'S MAIDEN NAME <i>Anna Bodeman</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>				16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT & ADDRESS <i>Mrs Lula Long</i>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							INTERVAL BETWEEN ONSET AND DEATH
443 IMMEDIATE CAUSE (A) <i>Cerebral Hemorrhage (second episode)</i>							<i>?</i>
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
(C) <i>Chr, hypertensive cardio-vascular disease</i>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> et work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Oct. 20</i> , 19 <i>55</i> , to <i>Oct. 25</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>Oct. 20</i> , 19 <i>55</i> , and that death occurred at <i>10:31</i> M, from the causes and on the date stated above.							
SIGNATURE <i>Willard P Hudson M.D.</i>				ADDRESS (Street, city, town, state) <i>Forest Hill Md</i>		DATE SIGNED <i>10/28/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Oct 29 1955</i>		NAME OF CEMETERY OR CREMATORY <i>Mountain Christian</i>		LOCATION (City, town, or county) <i>Joppa Md</i>	
24. REC'D BY REGISTRAR <i>10-31-55</i>		REGISTRAR'S SIGNATURE <i>Bruce Lowwood</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>W. H. Archer</i>		ADDRESS	



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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-25 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 9796 CERTIFICATE OF DEATH

09813  
Reg. Dist. No. 185

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Hartford County</u>		STATE <u>Maryland</u> COUNTY <u>Hartford</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u>		TOWN <u>Edgewood</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u>		LENGTH OF STAY (in this place)		STREET ADDRESS (If rural give location) <u>Edgewood Maryland</u>		X	
TOWN <u>Edgewood</u>				STREET ADDRESS			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>John A. Martin</u>				<b>4. DATE OF DEATH</b> (Month) <u>October</u> (Day) <u>9</u> (Year) <u>1955</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>7/8/1893</u>	
9. AGE last birthday <u>62</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>Store Keeper</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store Keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles D. Martin</u>				14. MOTHER'S MAIDEN NAME <u>Mary Webb</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>230-27-4756</u>		17. INFORMANT'S ADDRESS <u>Leota D. Martin Edgewood Md</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>230-27-4756</u>		17. INFORMANT'S ADDRESS <u>Leota D. Martin Edgewood Md</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
IMMEDIATE CAUSE (A) <u>Bronchogenic Carcinoma</u>						<u>about 6 months</u>	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 20th, 1955</u> to <u>Oct 9th, 1955</u> , that I last saw the deceased alive on <u>Oct 9th, 1955</u> , and that death occurred at <u>6:24 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Howard C. Martin</u>		ADDRESS (Street, city, town, state) <u>420 N. Union Ave. Harford Md</u>		DATE SIGNED <u>10/9/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct. 12, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Mountain Christian</u>		LOCATION (City, town, or county) <u>Harford Md</u>	
24. REC'D BY REGISTRAR <u>Oct 10 - 1955</u>		REGISTRAR'S SIGNATURE <u>A. L. Lewis M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Howard C. Martin</u>		ADDRESS <u>Harford Md</u>	

# CERTIFICATE OF DEATH

1935

1. FULL NAME OF DECEASED

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF REGISTRAR

NAME OF CLERK

NAME OF ASSISTANT

NAME OF OFFICIAL

NAME OF WITNESS

PHOTOCOPY

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MD. IT IS TO BE KEPT FOR A PERIOD OF FIFTY YEARS. IT IS TO BE MADE AVAILABLE TO THE PUBLIC UPON REQUEST. IT IS TO BE MADE AVAILABLE TO THE PUBLIC UPON REQUEST.

BUREAU V. 8

OCT 17 1935

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# 9797

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. **09814**No. **181**

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Abingdon</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Abingdon</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Bel Air Ave in front of Post Office</u>				STREET ADDRESS (If rural, give location) <u>Long Bar Harbor</u>			
3. NAME OF DECEASED: (Type or Print)		(First) <u>Joseph</u>		(Middle) <u>Masek</u>		(Last)	
				4. DATE OF DEATH		(Month) <u>October</u> (Day) <u>7</u> (Year) <u>1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>April 28 1881</u>	9. AGE last birthday: <u>74</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Retired farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Farm</u>		11. BIRTHPLACE (State or foreign country): <u>Czechoslovakia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Joseph Masek</u>				14. MOTHER'S MAIDEN NAME: <u>Anna Rosektrave</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		(If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>218-18-9671</u>		17. INFORMANT & ADDRESS: <u>Anna Masek, Abingdon, Maryland.</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>420.1</u> Immediate cause (a) <u>Coronary occlusion</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)						INTERVAL BETWEEN ONSET AND DEATH	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE <u>Gerald E Palmer</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>10/7/55</u> M. D. DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>							
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>10/10/55</u>		NAME OF CEMETERY OR CREMATORY: <u>Bakers Cemetery</u>		LOCATION (City, town, or county) (State): <u>Abingdon Maryland.</u>	
DATE REC'D BY LOCAL REG. <u>October 9-55</u>		REGISTRAR'S SIGNATURE: <u>Nellie G. Perry</u>		24. FUNERAL DIRECTOR: <u>John G. Yarrington - Abingdon Md.</u>		ADDRESS:	



BUREAU V. S.

OCT 11 1955

RECEIVED

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INSTRUCTIONS

**1** TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**1** TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09815

9814

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Hartford</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Hartford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Gibson MD</u>		<u>30 years</u>		TOWN <u>Gibson</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00				1			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>John T Monahan SR</u>				<u>Oct 3 1955</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b> yrs.	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<u>M</u>	<u>White</u>	<u>MARRIED</u>	<u>July 4 - 1875</u>	<u>80</u>	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>Retired</u>		<u>Carpenter</u>		<u>Upper Cross Rds</u>		<u>US</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>John T Monahan</u>				<u>Mary Cain</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, of unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
		<u>216-10-7494</u>		<u>Mrs. John T Monahan Sr Forest Hill, Md</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<u>422.1</u> IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>				<u>36 hr</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Myocarditis</u>				<u>5 yr</u>			
				<u>5 yr</u>			
<b>19. DATE OF OPERATION</b>				<b>19b. MAJOR FINDINGS OF OPERATION</b>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) M.		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from Aug 15 1955, to Oct 3, 1955, that I last saw the deceased alive on Oct 1st, 1955, and that death occurred at 7:00 A.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>DATE SIGNED</b>			
<u>F P Smudgrass M.D.</u>				<u>Harlington Md Oct 3-55</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>Burial</u>		<u>Oct 5/55</u>		<u>St Ignatius</u>		<u>Hickory Md</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>			
<u>10-3-55</u>		<u>Priscilla Lowwood</u>		<u>Joseph T. T. Bel Air Md</u>			



9798

09816  
Reg. Dist.

Items 2, 5, 8, 9, 12, 13, 14

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. ....

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Harford</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>*****</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)	
TOWN <u>Harvards Grace</u>	<u>10 minutes</u>	TOWN <u>Baltimore</u>	<u>3/10/54</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u>		STREET ADDRESS (If rural, give location) <u>708 W. Fairmount Avenue</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>Rudolph</u>	(Middle) <u>J.</u>	(Last) <u>Moore</u>	(Month) <u>October</u> (Day) <u>7</u> (Year) <u>1955</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Unknown</u>	8. DATE OF BIRTH: <u>Unknown</u>
9. AGE last birthday: <u>Approx. 36 yrs.</u>		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Unknown</u>		14. MOTHER'S MAIDEN NAME: <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS:	

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			
<u>420.1</u> Immediate cause (a) <u>Coronary occlusion</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	
21c. (City or town) (County) (State)		21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>Gerald C Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>10/8/55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>REMOVAL</u>		DATE THEREOF <u>OCT 12 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>UNION MEDICAL SCHOOL</u>		LOCATION (City, town, or county) (State) <u>29 S GREEN ST</u>	
DATE REC'D BY LOCAL REG. <u>Oct. 24, 1955</u>		REGISTRAR'S SIGNATURE <u>Dr. A. L. Lewis</u>	
24. FUNERAL DIRECTOR <u>Duffel Bldg</u>		ADDRESS <u>1800 E 104 BARO ST</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 25 1955

RECEIVED



## CERTIFICATE OF DEATH

Reg. Dist. No. 180

9815

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Harford</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Harford</b>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>Abingdon</b>		<b>25 yrs.</b>		TOWN <b>Abingdon</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>Emily</b> (Middle) <b>Frances</b> (Last) <b>Morkosky</b>				(Month) <b>Oct.</b> (Day) <b>13,</b> (Year) <b>19 55</b>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<b>female</b>	<b>white</b>	<b>married</b>	<b>Mar. 27, 1917</b>	<b>38</b> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<b>Housewife</b>		<b>none</b>		<b>Baltimore, Md.,</b>		<b>U.S.A.</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<b>James Chovjan</b>				<b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<b>no</b>		<b>none</b>		<b>Bohus Morkosky, Abingdon, Md.,</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
002X IMMEDIATE CAUSE (A) <b>Tuberculosis Far advanced</b>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <b>Pulmonary with cavitation</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>7-21</b> , 19 <b>49</b> , to <b>10-13</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>10-13</b> , 19 <b>55</b> , and that death occurred at <b>4 P</b> M, from the causes and on the date stated above.							
SIGNATURE <b>Indo O Hodous</b>				ADDRESS (Street, city, town, state) <b>Edgewood Md</b>			
M.D. <b>Edgewood Md</b>				DATE SIGNED <b>10-14-55</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>Oct. 17, 1955</b>		<b>Holy Redeemer</b>		<b>Baltimore Md.</b>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <b>Oct 15, 1955</b>		<b>Norma S. Moore</b>		<b>Howard K. McComas &amp; Son</b>		<b>Abingdon, Md.</b>	

INSTRUCTIONS

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TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

BUREAU A 5

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9799 CERTIFICATE OF DEATH

09818

Reg. Dist. No. 185-

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Harford</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>Harford</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Harford</i>		<i>8 days</i>		TOWN <i>Harford</i>		<i>24</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Harford Memorial</i>				STREET ADDRESS (If rural give location) <i>397 Wilson St.</i>			
<b>3. NAME OF DECEASED</b> (Type or Print) <i>Elizabeth</i>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <i>October 13 1955</i>			
5. SEX <i>female</i>		6. COLOR OR RACE <i>C</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>		8. DATE OF BIRTH <i>11/8/1886</i>	
9. AGE last birthday <i>69</i> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>NONE</i>		11. BIRTHPLACE (State or foreign country) <i>CARLYLE, Pa.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>							
13. FATHER'S NAME <i>HENRY McFARLAND</i>				14. MOTHER'S MAIDEN NAME <i>UNKNOWN HAURE de Grace</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>no</i>				16. SOCIAL SECURITY NO. <i>UNKNOWN</i>		17. INFORMANT & ADDRESS <i>Phillip Fickins</i>	
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Uremia.</i>							
ANTECEDENT CAUSE(S) DUE TO <i>Hypertensive C-V. Disease</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO <i>Diabetes Mellitus. Syphilis.</i>							
STATING UNDERLYING CAUSE LAST. (C) <i>2602</i>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <i>Oct 12 55</i>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. A. M. P.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>October 5, 1955</i> , to <i>October 13, 1955</i> , that I last saw the deceased alive on <i>Oct 12 55</i> , and that death occurred at <i>7:45 A.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>A. Sandeeki M.D.</i>				ADDRESS (Street, city, town, state) <i>15 Courtland St, BEL AIR Md</i>			
DATE <i>Oct. 15 - 1955</i>				DATE SIGNED <i>10.14.55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		DATE THEREOF <i>10/15/55</i>		NAME OF CEMETERY OR CREMATORY <i>MT CALVARY</i>		LOCATION (City, town, or county) (State) <i>Aberdeen, Md</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <i>Oct. 15 - 1955</i>		<i>G. L. Lewis</i>		<i>M. Cunningham</i>		<i>Harford, Md</i>	

# EMOTIONAL STATE

1. Name of patient: \_\_\_\_\_  
 2. Date of birth: \_\_\_\_\_  
 3. Sex: \_\_\_\_\_  
 4. Race: \_\_\_\_\_  
 5. Religion: \_\_\_\_\_  
 6. Education: \_\_\_\_\_  
 7. Occupation: \_\_\_\_\_  
 8. Marital status: \_\_\_\_\_  
 9. Number of children: \_\_\_\_\_  
 10. Date of admission: \_\_\_\_\_  
 11. Date of discharge: \_\_\_\_\_  
 12. Date of death: \_\_\_\_\_  
 13. Cause of death: \_\_\_\_\_  
 14. Place of death: \_\_\_\_\_  
 15. Name of physician: \_\_\_\_\_  
 16. Name of hospital: \_\_\_\_\_  
 17. Name of city: \_\_\_\_\_  
 18. Name of state: \_\_\_\_\_  
 19. Name of country: \_\_\_\_\_  
 20. Name of continent: \_\_\_\_\_

## DEATH CERTIFICATE

WYOMING STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

00815

1. Name of patient: \_\_\_\_\_

2. Date of birth: \_\_\_\_\_

3. Sex: \_\_\_\_\_

4. Race: \_\_\_\_\_

5. Religion: \_\_\_\_\_

6. Education: \_\_\_\_\_

7. Occupation: \_\_\_\_\_

8. Marital status: \_\_\_\_\_

9. Number of children: \_\_\_\_\_

10. Date of admission: \_\_\_\_\_

11. Date of discharge: \_\_\_\_\_

12. Date of death: \_\_\_\_\_

13. Cause of death: \_\_\_\_\_

14. Place of death: \_\_\_\_\_

15. Name of physician: \_\_\_\_\_

16. Name of hospital: \_\_\_\_\_

17. Name of city: \_\_\_\_\_

18. Name of state: \_\_\_\_\_

19. Name of country: \_\_\_\_\_

20. Name of continent: \_\_\_\_\_

RECEIVED

BUREAU A. S.

OCT 18 1995

RECEIVED

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## INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filled with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09819

9816

## CERTIFICATE OF DEATH

Reg. Dist. No. 181

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Hartford</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Hartford</i>	
CITY (If outside corporate limits, write RURAL or end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL or end give nearest town)			
TOWN <i>X Aberdeen</i>				TOWN <i>Aberdeen Rural #1</i>		<i>X</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Rural #1 near Perryman.</i>				STREET ADDRESS (If rural give location) <i>near Perryman.</i>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <i>Blanche</i>		(Middle) <i>Nelson</i>		(Last) <i>Richardson</i>		<i>Oct. 12 1955</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>widowed</i>	8. DATE OF BIRTH <i>May 21st 1867</i>	9. AGE last birthday <i>88</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>George N. Nelson</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth Ann Gallup</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>no</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT & ADDRESS <i>Aberdeen P.O. #1. W.D.</i>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<i>422.2</i>				<i>Chronic Myocardial Degeneration</i>			
IMMEDIATE CAUSE (A)				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Oct. 11, 1955</i> , to <i>Oct. 12, 1955</i> , that I last saw the deceased alive on <i>Oct. 12, 1955</i> , and that death occurred at <i>4 A.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Howard A. Hollman, M.D.</i>				ADDRESS (Street, city, town, state) <i>Perryman, Md.</i>		DATE SIGNED <i>Oct. 13, 55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>10/15/55</i>		NAME OF CEMETERY OR CREMATORY <i>Spesutta Cemetery</i>		LOCATION (City, town, or county) (State) <i>Perryman Md.</i>	
24. REC'D BY REGISTRAR <i>Oct 14 - 55</i>		REGISTRAR'S SIGNATURE <i>Nellie R. Perry</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>John F. Barring</i>		ADDRESS <i>Aberdeen Md.</i>	





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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09820

9817

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH COUNTY <u>Harford</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Benson</u> OR TOWN <u>Benson</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Whittaker Mill Rd</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Harford</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Benson</u> OR TOWN <u>Benson</u> STREET ADDRESS (If rural give location) <u>Whittaker Mill Rd</u>	
3. NAME OF DECEASED (Type or Print) <u>Magdalena</u> (First) <u>SCHUMM</u> (Last)		4. DATE OF DEATH <u>Oct. 6</u> 19 <u>55</u> (Month) (Day) (Year)	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Oct 4.13.1863</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>Balt. more, Md</u>
13. FATHER'S NAME <u>Louis Knoll</u>		14. MOTHER'S MAIDEN NAME <u>Mary Hoffman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>—</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT & ADDRESS <u>Katherine Hesse, 833 E. Belve</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 904.9 IMMEDIATE CAUSE (A) <u>Congestive C-V Failure with Edema</u> ANTECEDENT CAUSE(S) DUE TO <u>Fracture of Left Hip, not healed</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Old age (92)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>20-25 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION <u>May 10, 1955</u>		19b. MAJOR FINDINGS OF OPERATION <u>Fracture of Neck of Left Humerus</u>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>—</u>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>Benson, Harford, Maryland</u>	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>Benson, Harford, Maryland</u>		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>May 4, 1955 5 PM</u>	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fell Heavily on her L Hip?</u>	
22. I hereby certify that I attended the deceased from <u>Sept 29, 1955</u> , to <u>Oct 6, 1955</u> , that I last saw the deceased alive on <u>Oct 1st, 1955</u> , and that death occurred at <u>9:40 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>H. Sundeeck M.D.</u>		ADDRESS (Street, city, town, state) <u>15 Courtland, Bal Air Md</u> DATE SIGNED <u>10.6.55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>10-10-55</u>	
NAME OF CEMETERY OR CREMATORY <u>SACRED HEART CEM.</u>		LOCATION (City, town, or county) (State) <u>7401 GERMAN HILL RD, MD.</u>	
24. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE <u>Lucilla Lowndes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles S. Guler</u> ADDRESS <u>401 S. CONKLIN ST., BALTO., MD.</u>	
DATE <u>Oct. 10, 1955</u>			

CERTIFICATE OF DEATH

Reg. Dist. No.

10440

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09821  
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 181

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Harford</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Harford</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)	
<u>x</u> TOWN <u>Aberdeen Rural.</u>	<u>approx 2 days.</u>	TOWN <u>Harrods Grace Rural. x</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Bush River Penna RR Sta.</u>		STREET ADDRESS (If rural, give location) <u>Webster</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>Christian</u>	(Middle) <u>Peter</u>	(Last) <u>Smith</u>	(Month) <u>October</u> (Day) <u>2</u> (Year) <u>1955</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED: <u>Married</u>	8. DATE OF BIRTH: <u>Dec 5-1903</u>
9. AGE last birthday: <u>51</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Self-employed business</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Garage</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>John H. Smith</u>		14. MOTHER'S MAIDEN NAME: <u>Matilda Bodt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No.: <u>216-07-6681</u>	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <u>Matilda Bodt, Harrods Grace Md.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
(a) <u>Fracture Cervical Vertebra</u>		
Immediate cause DUE TO		
(b) Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause DUE TO		
stating underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Home</u>	21c. (City or town) (County) (State) <u>Aberdeen Harford Md.</u>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>5:45 PM 10/5/55</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Threw self from Bridge</u>
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>Herold P. Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>10/2/55</u>
DEPUTY MEDICAL EXAMINER		ASSISTANT MEDICAL EXAM.
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>Oct 5-1955</u>	NAME OF CEMETERY OR CREMATORY <u>St. Paul Lutheran Cemetery</u>
LOCATION (City, town, or county) (State) <u>Aberdeen Maryland</u>	24. FUNERAL DIRECTOR: <u>John G. Farringham</u>	
DATE REC'D BY LOCAL REG. <u>Oct 4-1955</u>	REGISTRAR'S SIGNATURE <u>William G. Perry</u>	ADDRESS <u>med.</u>

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 6 1955

RECEIVED



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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09822

98-0

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <i>Harford</i>	STATE <i>Maryland</i>	COUNTY <i>Harford</i>	STATE <i>Maryland</i>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (In this place)
TOWN <i>Harford</i>	<i>80 yrs.</i>	TOWN <i>Harford</i>	<i>80 yrs.</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<i>10</i>		<i>226 D. Union Ave.</i>	
<b>3. NAME OF DECEASED</b> (Type or Print)		<b>4. DATE OF DEATH</b> (Month) (Day) (Year)	
<i>Beulah (First) Lyon (Middle) Spencer (Last)</i>		<i>10/7/55</i> 19	
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWER, DIVORCED</b> (Specify)	<b>8. DATE OF BIRTH</b>
<i>Female</i>	<i>White</i>	<i>Married</i>	<i>3/11/1875</i>
<b>9. AGE last birthday</b>	<b>10. IF UNDER 1 YEAR</b> (Months) (Days)	<b>11. BIRTHPLACE (State or foreign country)</b>	<b>12. CITIZEN OF WHAT COUNTRY?</b>
<i>80</i> yrs.		<i>Harford, Md.</i>	<i>U.S.A.</i>
<b>13. FATHER'S NAME</b>		<b>14. MOTHER'S MAIDEN NAME</b>	
<i>Geo. L. Lyon</i>		<i>Maria Pennington</i>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>	
<i>no</i>		<i>Unknown</i>	
<b>17. INFORMANT &amp; ADDRESS</b>		<b>18. MEDICAL CERTIFICATION</b>	
<i>Thomas Lyon, Harford, Md.</i>		<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>	
		<b>19. DATE OF OPERATION</b>	
		<b>20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner)	
		<b>21a. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>	
		<b>21b. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>	
		<b>21c. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>	
		<b>21d. INJURY OCCURRED While at work Not while at work</b>	
		<b>21e. HOW DID INJURY OCCUR?</b>	
		<b>22. I hereby certify that I attended the deceased from</b> <i>Sept 2</i> , 19 <i>50</i> , to <i>Oct 7</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>Oct 7</i> , 19 <i>55</i> , and that death occurred at <i>10:35</i> M., from the causes and on the date stated above.	
<b>SIGNATURE</b>		<b>DATE SIGNED</b>	
<i>A. L. Lewis, M.D.</i>		<i>10/10/55</i>	
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b>		<b>24. REC'D BY REGISTRAR</b>	
<i>Burial</i>		<b>REGISTRAR'S SIGNATURE</b>	
<i>10/10/55</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>	
<i>Angel Hill</i>		<b>ADDRESS</b>	
<i>Harford, Md.</i>		<i>Harford, Md.</i>	
<b>DATE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>	
<i>Oct. 10 - 55</i>		<i>Pennington, Harford, Md.</i>	





9819

09823

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist.

No. 180

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY	Harford		STATE	Maryland	
CITY (If outside corporate limits, write RURAL OR and give nearest town)	Abingdon		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN	Abingdon	
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS	(If rural, give location)	
3. NAME OF DECEASED: (Type or Print)			4. DATE OF DEATH		
(First) Audrey (Middle) E (Last) Thomas			(Month) October (Day) 17 (Year) 19 55		
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	10. IF UNDER 1 YEAR
female	white	married	Apr. 15, 1920	35 yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if)			10b. KIND OF BUSINESS OR INDUSTRY:		
Comptometer Operator			Automobile		
11. BIRTHPLACE (State or foreign country):			12. CITIZEN OF WHAT COUNTRY?		
Baltimore, Md.			U.S.A.		
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
Charles Keys			Mary L. Seifert		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY No.:		
no			?		
17. INFORMANT & ADDRESS:			Edward W. Thomas, Abingdon, Md.		

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
976X Immediate cause (a) Gunshot wound cerebrum					
DUE TO					
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO					
stating underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)		21c. (City or town) (County) (State)	
		Home		Abingdon Harford Md.	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
October 17, 1955 15 M.				Shot self with pistol	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE		M. D.			
Gerald C Palmer		10/17/55			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		LOCATION (City, town, or county) (State)	
Burial		Oct. 21, 1955		Joppa, Harford, Md.	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
Oct 22, 1955		Norma G. Moore		Howard K. McComas & Son, Abingdon, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 31

OCT 24 1955

RECEIVED

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**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09824

9871

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Hartford</u>		STATE <u>Md</u>		COUNTY <u>Hartford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Harre-de-Grace</u>		TOWN <u>Aberdeen</u>		TOWN <u>Aberdeen</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS		STREET ADDRESS			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hartford Memorial Hospital</u>		STREET ADDRESS <u>50 Raymond Ave</u>		STREET ADDRESS			
<b>3. NAME OF DECEASED</b>				<b>4. DATE OF DEATH</b>			
(First) <u>Eva</u>		(Middle) <u>M</u>		(Last) <u>Toner</u>			
(Type or Print)							
DATE <u>10 16 19 55</u>		DATE <u>10 16 19 55</u>		DATE <u>10 16 19 55</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>		8. DATE OF BIRTH <u>Oct. 29, 1895</u>	
9. AGE last birthday <u>56</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Felix Jawonsky</u>		14. MOTHER'S MAIDEN NAME <u>Mary ? Krager</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS <u>Richard J. Toner, Husband</u>		18. MEDICAL CERTIFICATION		19. DATE OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		IMMEDIATE CAUSE (A) <u>Cordian decompensation</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10-16-55</u>			
ANTECEDENT CAUSE(S) DUE TO		(B) <u>Bronchogenic carcinoma</u>					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE		(C) <u>UNDERLYING CAUSE LAST</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> el work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10-7</u> , 19 <u>55</u> , to <u>10-16</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10-16</u> , 19 <u>55</u> , and that death occurred at <u>4:55 P.</u> M, from the causes and on the date stated above.		SIGNATURE <u>E. J. Simon</u>		ADDRESS (Street, city, town, state) <u>Harre de Grace, Md.</u>		DATE SIGNED <u>10-16-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct. 19, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Bell Air Memorial Garden</u>		LOCATION (City, town, or county) (State) <u>Bell Air Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>A. L. Lewis</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John B. Tanning</u>		ADDRESS <u>Aberdeen Md</u>	
DATE <u>Oct. 19-1955</u>							

OCT 03 1995

RECEIVED

10913  
Reg. Dist. No. 185

2820  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

<b>I. PLACE OF DEATH:</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b>			
COUNTY <b>Harford</b>		MARYLAND		STATE <b>U</b>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>X TOWN Abingdon</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) <b>TOWN K 12X-1</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>McComas Funeral Home</b>				STREET ADDRESS <b>N 0</b> (If rural, give location)			
<b>3. NAME OF DECEASED:</b> (First) (Middle) (Last) <b>Unidentified (John Doe)</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>N 10 15 1955</b>			
<b>6. SEX:</b> <b>Male</b>		<b>6. COLOR OR RACE:</b> <b>Colored</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):</b> <b>U</b>		<b>9. AGE last birthday:</b> yrs. <b>50?</b> Months <b>11</b> Days <b>11</b> Hours <b>11</b> Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of work life, even if retired): <b>K</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY:</b> <b>K</b>		<b>11. BIRTHPLACE</b> (State or foreign country): <b>K</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>K</b>	
<b>13. FATHER'S NAME:</b> <b>N</b>				<b>14. MOTHER'S MAIDEN NAME:</b> <b>N</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service) <b>W</b>		<b>16. SOCIAL SECURITY No.:</b> <b>N</b>		<b>17. INFORMANT &amp; ADDRESS:</b> <b>N</b>			

<b>18. MEDICAL CERTIFICATION</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:</b> <b>929.8</b> <b>Immediate cause (a) Drowning</b> <b>DUE TO</b> <b>Antecedent cause(s) (b)</b> <b>Diseases or conditions, if any, giving rise to the above cause DUE TO</b> <b>stating underlying cause last (c)</b>					
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>					
<b>19a. DATE OF OPERATION:</b> <b>2</b>		<b>19b. MAJOR FINDING OF OPERATION:</b>			<b>20. AUTOPSY?</b> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
<b>21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>		<b>21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)</b> <b>River</b>		<b>21c. (City or town) (County) (State)</b> <b>Bush River in Harford County, Maryland</b>	
<b>21d. TIME (Month) (Day) (Year) (Hour) OF INJURY</b> <b>10/15/55 10 A. M.</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b> <b>Presumably drowned, accidentally.</b>	
<b>22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>					
<b>SIGNATURE</b> <i>William V. Smith</i>		<b>CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED</b> <b>DEPUTY MEDICAL EXAMINER <input type="checkbox"/></b> <b>ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/> 11/18/55</b>			
<b>23. BURIAL, CREMATION, REMOVAL (Specify):</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>	
<b>DATE REC'D BY LOCAL REG.</b> <b>Nov. 23, 1955</b>		<b>REGISTRAR'S SIGNATURE</b> <i>H. H. Hedrick</i>		<b>24. FUNERAL DIRECTOR</b>	
				<b>ADDRESS</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BUREAU V. S.

NOV 25 1955

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9802

## CERTIFICATE OF DEATH

09825

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		STATE <u>Md.</u> COUNTY <u>HARFORD</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>Harre-de-Grace</u>		LENGTH OF STAY (in this place) <u>12 days</u>		CITY OR TOWN <u>Harre-de-Grace</u>		CITY OR TOWN <u>Harre-de-Grace</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u>		STREET ADDRESS <u>RD # 1</u>		STREET ADDRESS (If rural give location)		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>ETHEL ELIZABETH WASHINGTON</u>				4. DATE OF DEATH <u>10-1-1955</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>3-19-1893</u>	
9. AGE last birthday <u>62</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private Family</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Samuel L. B. Kehly</u>				14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Banks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT & ADDRESS <u>Edward Washington</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
334X IMMEDIATE CAUSE (A) <u>Pulmonary Edema - Uremia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hemiplegia left -</u>				<u>12 days</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerosis - hypertension</u>				<u>10 years</u>			
19. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>10-1-1955</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 20, 1955</u> to <u>Oct 1, 1955</u> , that I last saw the deceased alive on <u>Oct 1, 1955</u> , and that death occurred at <u>3:50 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>James Walbert MD</u> M.D.				ADDRESS (Street, city, town, state) <u>Harre-de-Grace Md</u> DATE SIGNED <u>Oct 1, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10-5-55</u>		NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u>		LOCATION (City, town, or county) (State) <u>Churchville, Md.</u>	
24. REC'D BY REGISTRAR <u>OCT 3, 1955</u>		REGISTRAR'S SIGNATURE <u>A. L. Lewis M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur J. Bullard</u> ADDRESS <u>Harre-de-Grace, Md.</u>			

SMITHSONIAN

RECEIVED  
OCT 14 1956  
BUREAU V

# 3805 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Oct 10 1956</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>	
10. SIGNATURE OF DECEASED <i>John Doe</i>		11. SIGNATURE OF WITNESSES <i>Mr. &amp; Mrs. Doe</i>		12. SIGNATURE OF REGISTRAR <i>John Doe</i>	

RECEIVED  
OCT 14 1956  
BUREAU V

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09826

9873

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>HAVRE DE GRACE</u>		<u>3 DAYS</u>		TOWN <u>HAVRE DE GRACE</u>		<u>24</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>840 ONTARIO ST.</u>				STREET ADDRESS (If rural give location) <u>840 ONTARIO ST.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>MARY</u> (Middle) <u>HOBGOOD</u> (Last) <u>WILLIAM</u>				(Month) <u>OCT.</u> (Day) <u>4</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>FEMALE</u>	<u>WHITE</u>	<u>DIVORCED</u>	<u>Sept. 17, 1878</u>	<u>77</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>CLERK (RETIRED) U.S. F.B.I.</u>		<u>N.C.</u>		<u>N.C.</u>		<u>U.S.</u>	
13. FATHER'S NAME <u>WM. HENRY HOBGOOD</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA SANDERS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
		<u>215-07-8633</u>		<u>MR. STERLING P. WILLIAM</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION <u>HAVRE DE GRACE, MD.</u>		INTERVAL BETWEEN ONSET AND DEATH	
157X IMMEDIATE CAUSE (A) <u>Cardiac Insufficiency - Arteriosclerosis</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Suspected Carcinoma of pancreas</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 30, 1955</u> , to <u>Oct 4, 1955</u> , that I last saw the deceased alive on <u>Oct 4, 1955</u> , and that death occurred at <u>11:14</u> M., from the causes and on the date stated above.							
SIGNATURE <u>A. L. Lewis</u> M.D.				ADDRESS (Street, city, town, state) <u>Havre de Grace, MD.</u>		DATE SIGNED <u>10/14/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>OCT. 6 1955</u>		<u>ANGEL HILL CEM.</u>		<u>HAVRE DE GRACE, MD.</u>	
24. RECEIVED BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Oct. 5-1955</u>		<u>A. L. Lewis M.D.</u>		<u>P. Madison Mitchell</u>		<u>Havre de Grace, MD.</u>	



1

INSTRUCTIONS

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**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9874

## CERTIFICATE OF DEATH

09827

Reg. Dist. No. 181

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
31 TOWN <u>ABERDEEN</u>		<u>LIFE</u>		OR TOWN <u>ABERDEEN</u>		31	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>118 N. PHILADELPHIA, RD.</u>				STREET ADDRESS (If rural give location) <u>118 N. PHILADELPHIA, RD.</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>GEORGE MITCHELL WORTHINGTON</u>				<u>OCT. 1 1955</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<u>MALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>MAR. 2, 1882</u>	<u>73</u> yrs.	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>FIREMAN</u>		<u>A.P.G.</u>		<u>MD.</u>		<u>U.S.A.</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>JOHN WORTHINGTON</u>				<u>SARAH NELSON</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
				<u>MRS. LOTTIE MAGRAW WORTHINGTON</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<u>331X</u> IMMEDIATE CAUSE (A)				<u>Cerebral Hemorrhage</u>		<u>5 WK</u>	
ANTECEDENT CAUSE(S) DUE TO (B)				<u>Arterial Hypertension</u>		<u>5 yr</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>10-1-55</u>, 19<u>55</u>, to <u>10-1-55</u>, 19<u>55</u>, that I last saw the deceased alive on <u>10-1-55</u>, 19<u>55</u>, and that death occurred at <u>8 A.</u> M., from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>W. P. Madson</u> M.D.				<b>ADDRESS</b> (Street, city, town, state) <u>Aberdeen, Md.</u>		<b>DATE SIGNED</b> <u>10-3-55</u>	
<b>23. BURIAL, CREMATION REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION</b> (City, town, or county) (State)	
<u>BURIAL</u>		<u>OCT. 4 1955</u>		<u>ANGEL HILL CEM.</u>		<u>HAYRE DE GRACE, MD.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>DATE</u> <u>Oct-3-55</u>		<u>Mellie G Perry</u>		<u>R. Madson Mitchell</u>		<u>Hayre de Grace, Md.</u>	



INNOVATIONS